

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN9202	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 02 - LIC B. WING _____	(X3) DATE SURVEY COMPLETED 08/12/2019
NAME OF PROVIDER OR SUPPLIER HILLVIEW COMMUNITY LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 897 EVERGREEN STREET, PO BOX 769 DRESDEN, TN 38225		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 002	<p>1200-8-6 No Deficiencies</p> <p>This Rule is not met as evidenced by: A Life Safety survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulations Office of Health Care Facilities, on 08/12/19. During this Life Safety survey, Hillview Community Living Center was found in substantial compliance with the requirements of the rules of the State of Tennessee Department of Health, Board for Licensing Health Care Facilities Chapter 1200-08-6 Standards for Nursing Homes and the National Fire Protection Association (NFPA) 101 Life Safety (2012 Edition).</p>	N 002		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE